DARTMOUTH MEDICAL SCHOOL

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Beth Tanzman
Deputy Commissioner
State of Vermont
Department of Mental Health
108 Cherry Street, PO Box 70
Burlington, VT 05402-0070

Dear Ms. Tanzman:

Thank you for your letter of September 11, 2009 about our "conceptual proposal" in response to the RFP issued by the Vermont Department of Mental Health regarding acute psychiatric inpatient care. As requested, we respond, below, to the specific questions raised in this letter.

1. **How would you deal with the different treatment and systems cultures in Vermont? Specifically the higher acuity of individuals served in the community, the more limited use of inpatient services, and the different statutory framework for nonemergency involuntary interventions?**

The Department of Psychiatry is committed to providing client-centered recovery-oriented care in all of our clinical services – offering people who experience psychiatric difficulties services designed to help them meet their life health goals. Such services promote hope, engage individuals in a process of taking an active role in managing their lives and illnesses, and support their efforts to get on with life beyond illness.

The treatment culture in Vermont is consistent with these values; it aims to minimize the negative impact of illness on the lives of citizens who live with psychiatric vulnerabilities. In our proposed role of running an involuntary psychiatric unit in Vermont, we would avoid using it for people who can be cared for in a less restrictive environment and would move people to less restrictive levels of care as quickly as is reasonably safe and possible. Non-emergency involuntary outpatient interventions can be used to avoid involuntary hospitalization and also provide one pathway that is sometimes needed to help people who are hospitalized to move to a less intensive level of care. The strength of the comprehensive community mental health system in Vermont also provides resources that help to both prevent hospitalization and minimize the length of stay for those who do need it. With effective supports, even quite ill people can live safely and meaningfully in the community.

During the process of planning for hospital care in Vermont, Dartmouth will work with State officials and others to gain a deeper understanding of the Vermont culture and statutes. The Department of Psychiatry, however, already has considerable knowledge of the Vermont Mental Health system, based on our history of work within Vermont over the years. For example, the

White River Junction VA interacts closely with community mental health centers and their crisis services throughout the state. Moreover, The Dartmouth Psychiatric Research Center (PRC) has been involved in several state-wide projects in Vermont. And, lastly, several of our faculty members who will be involved in developing the new services in Vermont (including our Medical Director, Dr. William Torrey) have provided community mental health services in the Vermont system in the past, and thus have already gained some familiarity with the Vermont culture and statutes.

2. Would you consider a partnership with Springfield Hospital?

We decided to recommend building an inpatient unit on the grounds of the White River Junction VA for a number of reasons, including its proximity to the main campus of the DHMC academic medical center, and because the VA is one of the prime components of DHMC (along with the Dartmouth-Hitchcock Clinic, Mary Hitchcock Memorial Hospital, and Dartmouth Medical School). The Department of Psychiatry will be most successful in recruiting high-quality providers if the hospital service requested by the state of Vermont is located in close proximity to the White River Junction/Lebanon area – near to Dartmouth Hitchcock Medical Center. Locating the program in White River Junction (on the campus of the VA Medical Center), and thus having it exist within the broader academic medical center with high quality providers and access to specialty consultants, will ensure that the quality of the service is at a high level. This location will allow trainees to actively participate, a feature that creates a pipeline for recruiting future excellent clinicians into the service. We are concerned that locating the program some distance from DHMC, such as at Springfield Hospital, would cause it to lose many of its potential strengths.

In addition, the "learning curve" of developing the program at Springfield Hospital would require considerable time – Dartmouth would need to learn about the staff, culture, physical plant and, indeed, the internal workings of Springfield Hospital, if it were to attempt to build a program there. Working on a project as complex as that proposed in the RFP when the partners are not familiar with each other would add a significant level of complexity -- a level of complexity that would decrease the efficiency of the development and operation of the effort.

3. What is your track record of working in Vermont? Do you have specific links with Vermont's designated community mental health agencies?

The Department of Psychiatry has a long history of providing psychiatric service in community mental health centers in Vermont – including the Clara Martin Center and HCRS, as well as in centers located in Rutland and St. Johnsbury. Our affiliate, West Central Behavioral Health (WCBH), has provided psychiatric care within the Clara Martin Center since 1989 and continues to do so. This collaboration resulted in the successful recruitment of a medical director at Clara Martin, and in the placement of psychiatrists and a nurse practitioner in the center. Likewise, the Department of Psychiatry has provided child psychiatry services at the Center, as well as at HCRS. Lastly, for many years, both the core Department and its affiliate WCBH have provided psychiatrists in the Northeast Kingdom Human Service. The Department has recently begun providing clinical supervision in child psychiatry to a nurse practitioner at Rutland, and we are in active discussions regarding recruiting a psychiatrist to provide telepsychiatry services at Rutland and other CHMCs in Vermont.

In addition to the provision of direct services, the Dartmouth Psychiatric Research Center (PRC) has been involved with the CMHC system in Vermont for many years. Vermont participated in the PRC-based National Implementing Evidence-Based Practices project that focused on implementing and studying the implementation of effective services in CMHCs. In addition to this specific project, for many years, Vermont has contracted with the PRC to provide training and support to the Vermont community mental health system for implementation of evidence-based practices such as supported employment and services for people with co-occurring substance use disorders and mental illnesses.

4. **Please describe the corporate (organizational) structure between the Dartmouth Medical School Department of Psychiatry and Dartmouth Hitchcock Medical Center. An organizational chart would be helpful.**

We include as attachments organizational charts for Dartmouth-Hitchcock Medical Center, Dartmouth Medical School (DMS), and the Department of Psychiatry. The Department is technically part of DMS, reporting to the Dean. However, as Chairman of the Department of Psychiatry, Dr. Alan Green reports both to the Dean and to the Presidents of DHMC.

5. **How can a free standing hospital of 15 – 20 beds be viable (programmatically, fiscally etc.?).**

We recognize that the optimal size of an inpatient unit is between 20 - 24 beds, from a financial perspective. However, we are under the assumption that the State is interested in the unit having approximately 15 beds. We are willing to work closely with the State officials to plan the exact size and structure of the unit – based on the needs within Vermont.

6. **Please provide a letter or statement from the VA system regarding this proposed collaboration or a letter from Dr. Andrew Pomerantz endorsing this proposal.**

We provide a letter, as requested, from Dr. Pomerantz as an attachment to this note.

7. **Please describe in more detail how the proposed program would work with peers and family members and any relevant examples of work you may already undertake with peers and families in state hospital type services.**

Working closely with peers and family members is essential in recovery-oriented care. At this stage in the planning process, however, it is premature to specify the details of this element of the programming. We anticipate that the Department would work closely with relevant groups in Vermont in establishing these programmatic plans and assess national models that could be considered by the planning group for implementation in Vermont. Many innovative programs have been developed in recent years; this project would create an opportunity for Dartmouth to develop a model program in partnership with consumers and families in Vermont.

Currently, the Department provides state hospital care at New Hampshire Hospital in New Hampshire and Riverview Hospital in Maine. We provide here descriptions of the relevant programs at these sites, and we mention as well our commitment to peer support and families in our community mental health services and in our research and writing.

New Hampshire Hospital:

Peer Support Services: At New Hampshire Hospital (NHH), there is a regularly scheduled meeting with peer support members and patients (who have the appropriate hospital privileges) held in the patient library. Discussions revolve around recovery/empowerment, how to deal with hospitalization, and how to transition back to the community. Peer Support services opportunities in the community are also discussed.

NHH has a Peer Support Services Bulletin Board prominently displayed in the second floor lobby. This Board has descriptions of Peer Support resources available throughout the state, with contact addresses, numbers, and e-mail addresses. Peer support Warm Line phone numbers available in all regions are also clearly noted. A calendar of events is also displayed.

NHH has vans available to take patients who have community privileges to the Concord Peer Support program twice weekly to participate in Peer Support programs. These programs include: Health and Wellness, Recovery/Empowerment, Social Skills, Community Living Skills, and Tools for Life groups.

Family Services: The National Alliance on Mental Illness (NAMI) - New Hampshire Branch Family Advisory Committee meets on a quarterly basis with New Hampshire Hospital administration. Chaired by the NHH Administrator of the Community Integration Department, the hospital gives the Committee updates on clinical services and programs, status of hospital-wide and customer service initiatives, and volunteer services. NAMI members update the hospital on the findings of the NAMI Citizen Advisory Committee (see below). Patient/family provider satisfaction survey results are also reviewed with the NAMI members. The NAMI NH Citizen Advisory Committee is a group of NAMI members who have access to patient units on an unscheduled, randomly chosen time. They meet with unit staff and patients, and conduct an independent assessment of how services are provided to patients. They can suggest improvements to NHH staff per their visit, and their suggestions are reviewed in the quarterly Family Advisory Committee meetings. On a more direct clinical level, families are routinely invited into clinical care discussions and decisions (when permission has been granted). The clinical teams provide families with education and guidance and learn from the families' experiences. The aim is to work toward having the hospitalized individual, the family and the clinical team all knowledgably working together to foster health.

Riverview Hospital:

Peer Support Services: Riverview Hospital (RH) has worked closely with the Amistad Peer Support and Recovery Agency of Portland since 2004. The Amistad agency is contracted by the hospital to supply peer support workers to all units of the hospital as well as to its ACT team and outpatient clinics. Peers work under the supervision of the Social Work Department and provide a multitude of services including attending all admissions, attending all treatment team meetings, and being available on the wards to assist clients in meeting their recovery goals and in dealing with staff-client conflicts and to providing a perspective to staff on the avoidance of re-traumatizing events. In Riverview Hospital, peers also serve as the first responders to all client grievances and concerns, helping to resolve conflicts at the lowest level possible. This program is one of the oldest and best organized peer support programs of any state hospital in the country.

Family Services: RH also has had a long and supportive history of working collaboratively with families of clients, and it has had strong bonds with the Maine chapter of NAMI and by affording space in the hospital for them to run family support groups. The hospital itself runs a weekly family support group for current clients led by a staff psychologist. In general, hospital staff and peer support workers jointly encourage clients to allow identified family members to participate in the client's recovery goals -- by attending treatment activities and treatment team meetings. Finally for many years Riverview Hospital has had a Quality Advisory Council composed of consumers, former consumers, families of current and past clients, and non-consumer community members. This Council meets often and provides advice and suggestions to senior hospital management.

Community mental health experience:

The Department also has experience with family and peer support in our CMHC settings. For example, the faculty at West Central Behavioral Health (WCBH) provided support to the development of innovative independent peer support centers in Claremont and Lebanon, NH. In addition, WCBH developed and still offers peer support services as part of the usual services in its community support programs.

Other Departmental activities related to peer family involvement in care:

Resident training:

Our psychiatry resident training program emphasizes seminars related to the nature and importance of peer support and family psychoeducation. The sessions are taught by experienced consumers who offer peer support and by family members with long experience interacting with the mental health system.

NAMI Involvement:

A number of Departmental faculty members have been recognized by NAMI as Psychiatrists of the Year. This honor has been bestowed upon Drs. Drake, Cobble, Torrey, DeNesnera, Bartels and others. In addition, a number of members of the faculty have served on the board of NAMI-NH and the executive director of NAMI-NH is a member of the Dartmouth Department of Psychiatry.

Research and program development:

The Department's Psychiatric Research Center has been a leader in developing peer support systems and recovery-oriented care. We list here a few representative articles reflecting that work:

- Becker DR, Torrey WC, Toscano R, Wyzik PF, Fox TS: Building recovery-oriented services: Lessons from implementing IPS in community mental health centers. Psychiatric Rehabilitation Journal 22(1): 51-54, 1998.
- Deegan, P.E. & Drake, R.E. (2006). Shared decision making and medication management in the recovery process. Psychiatric Services, 57, 1636-1639
- Deegan, P.E., Rapp, C., Holter, M., et al. (2008). A program to support shared decision making in an outpatient psychiatric medication clinic. Psychiatric Services, 59, 603-605.
- Noordsy D, Torrey WC, Mueser KT, Mead S, O'Keefe C, Fox L: Recovery from severe mental illness: An intrapersonal and functional outcome definition, International Review of Psychiatry 14:318-326, 2002

- Torrey WC, Mead S, Ross, G: Addressing the social needs of mental health consumers when day treatment programs convert to supported employment: Can consumer-run services play a role? Psychiatric Rehabilitation Journal 22(1): 73-75, 1998.
- Torrey WC, Rapp CA, Van Tosh L, Appell C, Ralph RO: Recovery Principles and Evidence-Based Practice: Essential Ingredients of Service Improvement, Community Mental Health Journal, 41:91-100, 2005
- Torrey WC, Wyzik PF: The recovery vision as a service improvement guide for community mental health center providers. Community Mental Health Journal, 36(2): 209-216, 2000.

8. Please describe in more detail how and what resources would be shared with the Veterans Hospital. When and how would veterans use the proposed program?

Should this project move forward, the Veterans Hospital would develop contracts with the new hospital program to supply "hotel" services to the hospital such as food, cleaning services, and security, as appropriate. Vermont veterans, like other Vermonters, would be able to use the services of the new hospital program when they meet criteria for admission to it. When they no longer need the level of care provided by this hospital, they would move to voluntary inpatient or outpatient services within the VA, as appropriate.

9. Would the proposed program be an IMD? (Being next to the VA hospital and therefore having more than 16 beds).

This topic will need to be carefully addressed with the Vermont officials. We understand that we are being asked to develop a unit with approximately 15 beds. Since it will not be administratively connected to the VA, we do not believe it would qualify as an IMD. If the State would like the program to be larger than 16 beds, we would be willing to work together to determine how such a program could be developed.

10. How would the construction of a new building be funded?

The plan for funding the construction of the new building will need to be developed in conjunction with State officials, should we be asked to proceed with this Dartmouth proposal. At present, Dartmouth is not in a position to provide construction funding, but we would be glad to partner with the State to attract federal or other sources of funding that might be available.

11. What would happen if patients become ill and need inpatient medical treatment? Would they be treated in NH (how would the jurisdictional issues be addressed)? How would the full psychiatric needs of a patient be met if they required transfer to a general hospital?

Medical treatment of patients on the unit would be under the supervision of Dartmouth internists working in collaboration with the Dartmouth unit psychiatrists. Patients in need of inpatient medical treatment (on a medical or surgical unit) would be treated at the Veterans Hospital if they were eligible veterans and the hospital had the services that they require. If they were not veterans, or the medical services were not available at the VA (even though they were veterans), they would be treated at Dartmouth-Hitchcock Medical Center, assuming that the legal issues regarding transferring involuntary patients into New Hampshire were able to be resolved (note – prisoners from Vermont currently receive inpatient medical care in New Hampshire). If this were not possible, we would work with the Vermont Department of Mental Health to develop appropriate relationships with a nearby Vermont-based hospital to provide inpatient

medical treatment. Treatment of patients at DHMC would be preferable, since doing so would allow the psychiatric needs of people receiving medical care to be served by the active psychiatric consultation services of the hospital. If this were not possible, other arrangements to ensure adequate psychiatric coverage during the period of medical inpatient admission would be developed.

12. What experience do you have with involuntary psychiatric inpatient admissions and care?

As noted in the proposal, both New Hampshire Hospital (NHH) and Riverview Hospital (RH) in Maine are busy involuntary inpatient facilities that have been led clinically by the Department of Psychiatry for many years – NHH for over 20 years and RH for over 7 years. We note here the relevant sections of our previous proposal:

> "The Department assumed clinical leadership of New Hampshire Hospital (NHH) over 20 years ago. The Dartmouth-New Hampshire partnership at NHH transformed a struggling clinical service to one that was described in a national report by Dr. E. Fuller Torrey as "the best public psychiatric hospital in the country." Seventeen faculty psychiatrists provide care at NHH, conducting clinical and neuropsychological evaluations, developing clinical formulations, prescribing and managing medications, doing psychotherapy and providing clinical direction to NHH-employed clinical staff. A Dartmouth Medical Director oversees all clinical care, provides psychiatric consultation to NHH clinical leaders, and consults with NHH executive administrators regarding all aspects of NHH operations and program development. This program provides for psychiatric care within this 240-bed facility that admits approximately 2,500 patients annually.
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> Likewise, the Department's involvement with Maine, which began in 2002, has led to substantial improvements in their largest state hospital, Riverview Psychiatric Center (formerly Augusta Mental Health Institute) in Augusta, ME. When the Department arrived, the hospital was under court receivership after a suit found noncompliance with a long-term consent decree. The Department's involvement was part of the State of Maine's plan to improve care, foster the recruitment of quality psychiatrists and address the many clinical issues leading to the receivership. The Department currently employs the hospital medical/clinical director and one other faculty psychiatrist at the hospital, and has facilitated the recruitment of five additional psychiatrists for full-time work. The hospital has been out of receivership since 2004, and has full JCAHO and CMS certification. Members of the Department's faculty from other clinical sites travel to Augusta to provide on-site consultations for complex patients 6-8 times/year. The Center contains 92 beds (with approximately 350 discharges per year), as well as two outpatient clinics, an ACT team, and 18 on-campus group home beds. The hospital has general involuntary patients and is the sole Maine facility for forensic patients."

13. Given the legal requirement that care be provided in the least restrictive environment, as well as the State's policy of favoring voluntary care whenever possible, and the fact that the proposed program is specifically a high acuity, involuntary, and high security setting, how would the proposer ensure access to less restrictive and /or voluntary inpatient care when appropriate? No less restrictive unit would be available at the VA hospital unless the patient was also a veteran.

The new facility would meet Vermont's need for this level of care; but the unit would need to be just one element in a larger coordinated system of care. The program will need to have close working relationships with the rest of the psychiatric inpatient hospital and community care infrastructure in Vermont (and including the inpatient psychiatric unit at DHMC) so that those in need of service could move smoothly out of this high level of care when a less restrictive level is possible. Unless requested by DMH, we would assume that the proposed unit on the grounds of the WRJ VA would not be designed to provide less restrictive levels of care itself. As noted in our proposal, the Department would be willing to work with the State to help design program improvements in the State system, as we have done in New Hampshire and elsewhere in the country.

14. Could you propose an alternative site closer to northern Vermont?

We believe that a site such as the WRJ VA in geographic proximity to DHMC is the optimal location for the proposed unit. The rationale for this is discussed in response to question #2, above.

15. How quickly could a planning process move? What resources could your organization commit to the planning process?

We are committed to moving forward quickly to plan the new inpatient facility at White River Junction. We are well aware, however, that numerous issues remain to be discussed and resolved, and we look forward to working with Vermont officials to make more concrete plans. Should the State of Vermont chose to move forward with our proposal, we will commit personnel to the planning process, but we anticipate that we will also need to hire new staff, including a project manager, to implement the full development of this project.

Sincerely,

Alan I. Green, M.D.